STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092304	A. BUILDING: _____ B. WING _____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE GARDENS	6701 CANDLEWOOD DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/25/24 - 04/26/24 with an exit conference via telephone on 04/26/24.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 staff (B) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry prior to hire at the facility. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 02/28/24 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 04/25/24 with no substantiated findings. -There was no HCPR check prior to 04/25/24. Telephone interview with the Administrator on 04/26/24 at 3:30pm revealed: -She did not know why Staff B did not have a HCPR check completed upon hire in February 2024. -The Human Resources Manager (HRM) was responsible for checking the HCPR upon hire of any new staff.	C 145		

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C 145	Continued From page 1 -There was no system to check behind the HRM to make sure the HCPR checks were completed upon hire. -The facility had been in transition, and she had not started a system to check but she was starting one now. Telephone interview with the HRM on 04/26/24 at 4:15pm revealed: -She realized on 04/25/24 when Staff B's personnel record was requested for review during the survey that there was no HCPR check for Staff B. -She was responsible for doing HCPR checks upon hire of any new staff. -The facility had been in a hiring crisis a couple of months ago and she hired several staff at one time. -She probably overlooked doing the HCPR check for Staff B. Attempted telephone interview with Staff B on 04/26/24 at 4:21pm was unsuccessful.	C 145		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	C 202		

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C 202	Continued From page 2 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 residents (#1) sampled was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #1's current FL-2 dated 01/31/24 revealed diagnoses included cerebrovascular accident and essential hypertension. Review of Resident #1's Resident Register revealed the resident was admitted to the facility from her private residence on 02/05/24. Review of Resident #1's tuberculosis (TB) skin tests revealed there was no documentation of any TB skin tests for the resident. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 04/26/24 at 11:53am was unsuccessful. Interview with the Administrator on 04/25/24 at 2:45pm revealed: -She and the facility's admission team were responsible for making sure residents had at least a one-step TB skin test upon admission and they had 30 days to get a second step TB skin test. -She could not locate any documentation of TB skin tests for Resident #1.	C 202		

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C 202	Continued From page 3 Telephone interview with Resident #1's primary care provider (PCP) on 04/26/24 at 2:34pm revealed: -She did not place TB skin tests for residents, but their provider's office sometimes had resident's tested using TB Gold blood work testing. -There was no documentation of Resident #1 having any TB skin tests or TB Gold blood work testing in her files. -Resident #1 did not have any symptoms of TB disease.	C 202		
C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the residents' physicians signed and dated care plans within 15 days of the assessment for 3 of 3 sampled residents (#1, #2, #3). 1. Review of Resident #1's current FL-2 dated 01/31/24 revealed: -The resident's diagnoses included cerebrovascular accident and essential hypertension. -The resident was documented as intermittently	C 240		

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C 240	Continued From page 4	C 240		

disoriented.
-The resident was documented as non-ambulatory and incontinent of bowel and bladder.
-The resident was documented as requiring total care by staff with activities of daily living (ADLs).

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 02/05/24.

Review of Resident #1's current assessment and care plan dated 02/01/24 revealed:
-The assessor completed and dated the assessment and care plan on 02/01/24.
-The resident was documented as being totally dependent on staff for all ADLs.
-The assessment and care plan were not signed or dated by the resident's primary care provider (PCP).

Refer to interview with the Administrator on 04/25/24 at 2:45pm.

Refer to telephone interview with the facility's contracted PCP on 04/26/24 at 2:34pm.

2. Review of Resident #2's current FL-2 dated 06/20/23 revealed:
-The resident's diagnoses included rheumatoid arthritis, cognitive communication deficit, essential hypertension, unsteadiness on feet, non-infective gastroenteritis and colitis, generalized muscle weakness, difficulty walking, and dysphagia.
-The resident was documented as intermittently disoriented.
-The resident was documented as semi-ambulatory and incontinent of bowel and bladder.

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C 240	Continued From page 5 -The resident was documented as requiring assistance by staff with bathing and dressing. Review of Resident #2's Resident Register revealed the date of admission was blank and the signature was not dated. Review of Resident #2's licensed health professional support (LHPS) evaluation dated 06/23/23 revealed the resident's date of admission to the facility was 06/21/23. Review of Resident #2's current assessment and care plan dated 06/23/23 revealed: -The assessor completed and dated the assessment and care plan on 06/23/23. -The resident required supervision by staff for eating. -The resident required extensive assistance by staff with toileting. -The resident was totally dependent on staff for ambulation, bathing, dressing, grooming, and transferring. -The assessment and care plan were not signed or dated by the resident's primary care provider (PCP). Refer to interview with the Administrator on 04/25/24 at 2:45pm. Refer to telephone interview with the facility's contracted PCP on 04/26/24 at 2:34pm. 3. Review of Resident #3's current FL-2 dated 01/29/24 revealed: -The resident's diagnoses included mild cognitive impairment, ataxia, repeated falls, dizziness, diverticulosis and myelopathy. -The resident was documented as intermittently disoriented.	C 240		

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C 240	Continued From page 6 -The resident was documented as ambulatory and incontinent of bowel and bladder. -The resident was documented as requiring assistance by staff with bathing and dressing. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 02/02/24. Review of Resident #3's current assessment and care plan dated 02/01/24 revealed: -The assessor completed and dated the assessment and care plan on 02/01/24. -The resident required supervision by staff for eating. -The resident required assistance by staff with toileting, bathing, dressing, and grooming. -The resident required stand-by assistance by staff with ambulation and transferring. -The assessment and care plan were not signed or dated by the resident's primary care provider (PCP). Refer to interview with the Administrator on 04/25/24 at 2:45pm. Refer to telephone interview with the facility's contracted PCP on 04/26/24 at 2:34pm. _____ Interview with the Administrator on 04/25/24 at 2:45pm revealed: -She was responsible for doing the assessments and care plans for the residents. -Once she completed the assessments and care plans, she left them at the facility. -The medication aides (MAs) were responsible for putting the assessments and care plans in the facility's contracted primary care provider's (PCP) folder so the PCP could sign during her monthly visits to the facility.	C 240		

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C 240	Continued From page 7 -She audited resident records every 6 months and she had not noticed the resident's care plans had not been signed by the provider. -A former MA/Supervisor would have been responsible for getting those care plans signed during that time period. Telephone interview with the facility's contracted PCP on 04/26/24 at 2:34pm revealed: -She went to the facility once a month to see residents. -The facility staff usually handed her any paperwork that needed to be signed or faxed it to her. -There was no folder at the facility with paperwork for her to sign to her knowledge. -If the facility had provided the residents' assessments and care plans, she would have reviewed and signed them.	C 240		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#2, #3) sampled including errors with antibiotics used to treat infections (#2) and a topical patch	C 330		

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C 330	Continued From page 8	C 330		

used to treat dementia related to Alzheimer's disease and Parkinson's disease (#3).

The findings are:

1. Review of Resident #2's current FL-2 dated 06/20/23 revealed diagnoses included rheumatoid arthritis, cognitive communication deficit, essential hypertension, unsteadiness on feet, non-infective gastroenteritis and colitis, generalized muscle weakness, difficulty walking, and dysphagia.

Review of Resident #2's hospital discharge summary dated 03/26/24 revealed:
-The resident was admitted to the hospital on 03/22/24 with complaints of weakness and somnolence.
-The resident was discharged on 03/26/24 and discharge diagnoses included pneumonia due to gram-positive bacteria, systemic inflammatory response syndrome, permanent atrial fibrillation, and hyponatremia (low sodium levels).
-There was an order for Cefdinir 300mg 1 capsule 2 times a day for 3 days. (Cefdinir is an antibiotic used to treat infection.)
-There was an order for Doxycycline 100mg take 1 capsule 2 times a day for 5 doses. (Doxycycline is an antibiotic used to treat infection.)

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for Cefdinir, and none was documented as administered.
-There was no entry for Doxycycline, and none was documented as administered.
-Neither of the orders for the two antibiotics were implemented as ordered on the hospital

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C 330	Continued From page 9 discharge summary dated 03/26/24. Observation of Resident #2's medications on hand on 04/25/24 at 5:52pm revealed: -There was no Cefdinir available for administration. -There was no Doxycycline available for administration. Interview with a medication aide (MA) on 04/25/24 at 5:58pm revealed: -He did not know Resident #2 had orders to receive Cefdinir and Doxycycline on the discharge summary dated 03/26/24. -He did not know why the orders were not implemented. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 04/25/24 at 3:29pm revealed: -The pharmacy never received Resident #2's hospital discharge summary dated 03/26/24. -They did not dispense Cefdinir or Doxycycline because they did not receive the discharge summary with the orders. -The facility staff were supposed to fax medication orders to the pharmacy so the pharmacy could enter the orders into the eMAR system and dispense the medication. Interview with the Administrator on 04/25/24 at 2:45pm revealed: -She was not aware Resident #2 did not receive Cefdinir and Doxycycline as ordered in March 2024. -The MA on duty when an order was received was responsible for faxing orders, including discharge summaries to the pharmacy. -The pharmacy entered the orders into the eMAR system and she checked the orders after the	C 330		

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pharmacy entered the orders into the eMAR system.
-She checked medication orders every 6 months but needed to check them more often.
-The MAs checked eMARs and medications on hand every shift.

Telephone interview with Resident #2's primary care provider (PCP) on 04/26/24 at 2:34pm revealed:
-She did not realize Resident #2 did not receive the antibiotics that were ordered upon discharge from the hospital in March 2024.
-Not receiving the antibiotics could have caused the resident's pneumonia to worsen and caused him another hospitalization.
-She last saw Resident #2 for a visit on 04/23/24 and he was not exhibiting symptoms of pneumonia.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

2. Review of Resident #3's current FL-2 dated 01/29/24 revealed:
-The resident's diagnoses included mild cognitive impairment, ataxia, repeated falls, dizziness, diverticulosis and myelopathy.
-There was an order for Exelon 4.6mg patch, apply 1 patch every morning, rotate sites.
(Exelon is a topical patch used to treat dementia related to Alzheimer's disease and Parkinson's disease.)

Review of Resident #3's hospital discharge summary dated 02/14/24 revealed:
-The resident was admitted to the hospital due to aggression.
-The resident was discharged from the hospital

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on 02/14/24 with discharge diagnoses of dementia with behavioral disturbance, hypothyroidism, hypertension, and cerebellar ataxia.
-The resident was having fecal incontinence with frequent loose stools which could be a side effect of the Exelon patch, so it was stopped on admission.
-There was an order to stop Exelon patch.

Review of Resident #3's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Exelon 4.6mg patch, apply 1 patch every morning, rotate sites and remove old patch, scheduled at 8:00am.
-Exelon patch was documented as administered from 02/03/24 - 02/12/24.
-It was documented the resident was out of the facility in the hospital from 02/12/24 - 02/14/24.
-Exelon patch was documented as discontinued upon discharge from the hospital on 02/14/24.
-Exelon patch was not documented as administered after 02/12/24.

Review of Resident #3's physician's orders from February 2024 - April 2024 revealed no orders to restart Exelon patch.

Review of Resident #3's March 2024 eMAR revealed:
-There was an entry for Exelon 4.6mg patch, apply 1 patch every morning, rotate sites and remove old patch, scheduled at 8:00am.
-Exelon patch was documented as administered from 03/14/24 - 03/31/24.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for Exelon 4.6mg patch,

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apply 1 patch every morning, rotate sites and remove old patch, scheduled at 8:00am.
-Exelon patch was documented as administered from 04/01/24 - 04/23/24.

Review of Resident #3's primary care provider (PCP) visit note dated 04/23/24 revealed an order to stop Exelon patch.

Observation of Resident #3's medications on hand on 04/25/24 at 4:01pm revealed:
-There was a supply of Exelon 4.6mgpatches dispensed on 02/01/24.
-There were 11 of 30 patches remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/26/24 at 12:35pm revealed:
-The order for Exelon was still showing as an active order in their eMAR system.
-The pharmacy did not receive orders to stop the medication on 02/14/24 or in April 2024.

Interview with the Administrator on 04/25/24 at 2:45pm revealed:
-She put a hold on the eMAR system for the Exelon patch when it was discontinued in February 2024.
-She did not actually discontinue the order in the eMAR system because the pharmacy usually entered all orders including discontinue orders.
-She was not sure why but the pharmacy never received the discharge summary with the order to discontinue the Exelon patch on 02/14/24.
-The order automatically "popped back up" on the eMAR 30 days later, on 03/14/24, since it was never discontinued out of the eMAR system.
-Resident #3's PCP discovered the Exelon patch had been restarted without an order during her visit at the facility on 04/23/24.

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C 330	Continued From page 13 -The PCP wrote another order on 04/23/24 to stop the Exelon patch because the resident was not supposed to be getting it. Telephone interview with Resident #3's PCP on 04/26/24 at 2:34pm revealed: -Resident #3's Exelon patch was stopped while he was in the hospital in February 2024 because it was causing the resident to have diarrhea. -She discovered the facility had restarted the Exelon patch without an order in March 2024 when she had a visit with the resident at the facility on 04/23/24. -She wrote an order to stop the Exelon patch again on 04/23/24. -Continuing to receive the Exelon patch could cause the resident to have diarrhea or could contribute to falls. Interview with Resident #3 on 04/25/24 at 6:23pm revealed he no longer received the Exelon patch, but he could not recall when he stopped receiving it.	C 330		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by:	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092304	A. BUILDING: _____ B. WING _____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE GARDENS	6701 CANDLEWOOD DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 444	Continued From page 14 Based on interviews and record reviews, the facility failed to ensure the county Department of Social Services (DSS) was notified of accidents or incidents for 1 of 1 resident (#3) sampled who had 2 falls requiring referral for emergency evaluation. The findings are: Review of Resident #3's current FL-2 dated 01/29/24 revealed: -Diagnoses included mild cognitive impairment, ataxia following cerebrovascular disease, repeated falls, dizziness, and myelopathy. -The resident was ambulatory and intermittently disoriented. -The resident required assistance with bathing and dressing. Review of Resident #3's facility progress note dated 02/05/24 at 2:40pm revealed: -The resident was found in his room on the bathroom floor. -Emergency Medical Services (EMS) was called to examine and treat the resident. -The resident had a bruise on his forehead and an ice pack was placed on his forehead. -There was no documentation that the county Department of Social Services (DSS) was notified. Review of Resident #3's record revealed there was no incident/accident report for the resident's fall on 02/05/24 that required evaluation and treatment by EMS and no documentation the county DSS was notified. Review of Resident #3's hospital emergency room (ER) provider note dated 03/06/24 revealed: -The resident was seen for a fall.	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 444	Continued From page 15 -The resident reported he lost his balance that morning while getting out of bed and hit the front of his head on the ground. -The resident had a 3cm hematoma (pooled blood/bruise) over his left eyebrow. Review of Resident #3's facility progress note dated 03/06/24 at 10:32pm revealed: -The resident was out of the facility in the morning and at the hospital due to a fall. -The resident had a bump on his forehead and came back to the facility by noon. -Ice was put on his forehead as instructed by the doctor -There was no documentation that the county DSS was notified. Review of Resident #3's record revealed there was no incident/accident report for the resident's fall on 03/06/24 that required evaluation and treatment at the hospital ER and no documentation the county DSS was notified. Interview with the Administrator on 04/25/24 at 4:58pm revealed: -The medication aide (MA) on duty at the time a fall occurred was responsible for completing and incident/accident report, including notifying the county DSS. -She could not locate any incident/accident reports for Resident #3's falls on 02/05/24 and 03/06/24. -Incident/Accident reports should have been completed for those falls and the county DSS should have been notified. -There was currently no system to follow-up to ensure incident/accident reports were completed and the county DSS was notified. Telephone interview with the county DSS Adult	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 444	Continued From page 16 Home Specialist (AHS) on 04/26/24 at 10:41am revealed: -She had not received any incident/accident reports or notifications of Resident #3's falls on 02/05/24 and 03/06/24. -The last incident/accident report that she received from the facility was on 07/04/23.	C 444		